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OF THE CHILDREN'S HOSPITAL

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CLINICAL PROCEEDINGS

OF THE CHILDREN'S HOSPITAL

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Editor's Note

The lead article in the current issue, "The Future of Pediatricians as Medical Specialists in the United States," by Charles D. May was delivered originally as the Joseph S. Wall Memorial Lecture at Children's Hospital on May 20, 1960. It has recently appeared in the November 1960 issue of the A. M. A. American Journal of Diseases of Children, and reappears here with the permission of Warren E. Wheeler, M.D., editor, and the author.

The Clinical Proceedings has chosen to reprint Dr. May's talk, both because it presents a very provocative and interesting point of view, but also because some of the statements made might be considered controversial by many physicians engaged in the private practice of pediatrics today. Some additional points of view are presented in the panel discussion which constitutes the second article in this issue. This is an edited transcript of the actual panel discussion which followed Dr. May's talk. In the third article, Dr. Layman presents her thoughts of how a pediatrician might further enrich his private practice; her ideas perhaps highlight how members of other professional disciplines can consistently add to our knowledge of the child and his behavior. Finally, Dr. Anderson, the present Chairman of the Medical Staff of Children's Hospital and a pediatrician in long-time active pediatric practice, delivers what might possibly be termed a "call to arms" to all other vigorous private practitioners of pediatrics. He helps to point up that whether we wish it or not, we all have a stake in this discussion. Reader comment is earnestly solicited.

The Future of Pediatricians as Medical Specialists in the United States*

CHARLES D. MAY, M.D.†

In order to flourish as a specialty any branch of medicine must meet a real need with a unique service and appeal to persons of ability as a chal-

* The Joseph S. Wall Memorial Lecture, presented as part of the Postgraduate Course in Pediatrics and Alumni Day at Children's Hospital, May 20, 1960.

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lenging and rewarding career. The people and the profession must believe the particular specialist is really necessary and whatever he offers cannot be done about as well by others. The caliber of man drawn to the specialty will be determined by the skills it requires and the distinction it affords.

At present the bulk of pediatricians are engaged in domestic practice—a form of health supervision among the young. Many pediatricians are not contented with this sort of general practice. There is a growing opinion that pediatrics is losing its appeal and prestige as a medical specialty in the United States, and not entirely because of the marked improvement in child health in this country.

At the same time the vitality of pediatrics as an academic enterprise—a valid subject of scholarly endeavor—has never been greater. Research on all aspects of health and disease in childhood is moving forward vigorously and with a sophistication that matches any other specialty in medicine. Numerous gifted persons are finding research into the unsolved riddles pertaining to children intriguing and significant. Teachers are fully aware that the vast knowledge which has accumulated concerning the development and disorders of children still excites the interest of medical students and hospital residents.

The question that bothers anyone considering pediatrics as a career is: What sort of opportunities does pediatrics offer for a challenging and rewarding life, either in practice or as an academic pursuit?

There appear to be divergent views on the best means of maintaining pediatrics in a prominent position among the branches of medicine. One sees pediatrics embracing the neighboring disciplines in social and behavioral sciences and enlisting an ever increasing number of pediatricians to serve all the needs of the entire child population with a form of general practice in preventive care. An alternative prospect is to secure a unique position by directing the efforts of fewer pediatricians to the roles of consultative specialists, teachers and investigators, and thus exercise leadership among a variety of groups prepared to share in meeting the complex needs of the child population.

The problem facing pediatrics as a specialty is to do something to elevate the status and appeal of the practice of pediatrics to that of a genuine and significant specialty, and to make certain that the prestige and validity of academic pediatrics are unquestioned regardless of how the domestic care of children may be accomplished.

The current situation calls for a candid review of the place of pediatricians in provision of care for children and in the conduct of the underlying research and teaching. A sound specialty cannot be based on the sentimental appeal of a fondness for children, for this attribute is not peculiar to pediatricians. It seems unrealistic for pediatricians to hope to

offer masterful guidance on every facet of child life within the traditional framework of a system of general medical practice.

It is the aim of this essay to set forth certain aspects of pediatrics that seem to deserve prominence in any consideration of the future activities of practitioners, investigators, educators and their organizations—all known to be devoted to the welfare of children. More attention will be given to broad principles than to specific suggestions, because when the former are clear it will be easier to tackle detailed planning. The opinions to be expressed are simply those of one interested party and cannot be construed to have any official standing. No one person or group has perfect qualifications or proprietary rights to deal with these topics.

CHOICE OF A VANTAGE POINT FOR PERCEIVING THE FUTURE

What ground should we seek from which to scrutinize the specialty of pediatrics most advantageously? There is a temptation to take the satisfaction or dissatisfaction of contemporary pediatricians as the point of departure. Much effort could be spent in collecting information by surveys and interviews to get a true picture of the pleasures or discontents of current members of the specialty and the influence their education had upon them. This might be of intense interest to those already committed to their careers, but of little concern to the public and the children of today and tomorrow. Likewise studies of the attitudes and personality characteristics of the existing pediatricians could throw light on the factors that determined their choice of a career and the reasons for their behavior under present circumstances. The latter approach might prove to be embarrassing and of no more than historical interest because the changing times will call for a new set of requirements for success and happiness in pediatrics in the years ahead.

Excessive self-analysis by those now engaged in pediatrics, without due regard for what will be the needs of children in the future, could prove futile. Imagine the spectacle of a guild of coachmen earnestly exploring their qualifications and working conditions on the eve of the disappearance of horse-drawn carriages! No one can deny the importance of keeping the career of pediatrics a satisfying one, but this is more apt to be achieved by accurate prediction of the opportunities ahead than by exhaustive enumeration of the factors operating in the present and the past. Who will choose to be a coachman when chauffeurs are wanted?

Firmer ground from which to contemplate the future of pediatrics may be reached by examining the probable needs of children in the future. Pediatricians will have to decide what portion of these needs they can reasonably expect to equip themselves to meet. In other words, the pediatrician, as a member of the medical profession, must not allow his am-

bitions to outstrip his abilities lest he take on greater responsibilities than he can manage or will find to his liking. The "whole child" may come to be viewed as a shibboleth and as a sign of illusion and conceit in any group which claims this to be its province. There are many who can make contributions to the care of the whole child—ranging from preachers to judges, not to say economists.

The unique role of most pediatricians for the forseeable future will be as physicians rather than as psychologists or general counsellors. Pediatricians become engaged in open competition with others in the social and behavioral sciences when they go beyond the legal sanction granted by the license to prescribe medical treatment. To remain a medical specialist the practicing pediatrician will be wise to make certain he continues to excel in provision of traditional medical care, while he strives to do this more effectively through acquisition of a somewhat better understanding of human behavior. He cannot fully succeed in carrying out his medical treatment unless he avoids conflict between his prescription and the bias and behavior of patients as human beings and members of society.

The pediatrician must bring his physical care into harmony with all other influences that affect behavior and happiness. This is the degree of comprehensive care and the extent of practice of mental hygiene to which most pediatricians can reasonably aspire as physicians, and it is all that is likely to be expected of them as *medical* specialists. Some pediatricians may choose to acquire real competence in psychiatry and have this as their primary interest, just as others will emphasize cardiology, endocrinology, etc. All pediatric specialists should become increasingly well informed regarding the fundamentals of biologic, psychologic and social development. For the great majority this would be an accessory to physical care in the traditional sense.

The cultivation of the mental health and social welfare of children will not be left entirely to pediatricians, and they should not delude themselves by supposing they can become a priestly class of counsellors on all things. Let those who would choose to be primarily counsellors set themselves apart or enter the ranks of other professions than medicine.

Unless limits are set, the primary task of physical care will be diluted and dislocated beyond recognition and the pediatrician may no longer be considered a physician. We need to know how much medical care children will need and how to provide it ideally in relation to human behavior and the coming social order. No more should be attempted than can be done with unique competence.

The difficulties of defining limits of responsibility are obvious. It is apparent, however, that there is a substantial difference in emphasis whether we aim to improve doctors or to create a new breed of counsellors; this is where we must make a clear choice before we go about planning the

education of pediatricians to play a significant role in the immediate and remote future. The choice we make and the men we train will ultimately be judged by the public in terms of the essentiality of the service offered to coming generations of children; success and happiness for future pediatricians will be more apt to come as natural by-products of realistic anticipation of children's needs than through any scheme to perpetuate the kind of pediatric practice that has evolved in recent years.

CONSEQUENCES OF THE CHOSEN VANTAGE POINT

If pediatricians take the social view and choose to assume a limited but appropriate share in meeting the needs of children—occupying themselves primarily with more sophisticated medical care—certain deductions are readily made. These would affect practitioners, educators and investigators and also the position of the specialty among the branches of medicine. Some of the consequences are considered in the following. The opportunities for careers in pediatrics in the future will be simultaneously delineated.

For the Practitioner

Over the years, the increase in the number of physicians in the United States limiting their practice to children has exceeded all expectations; an estimated 8,000 consider themselves pediatricians and more than 5,000 have received the Certificate of the American Board of Pediatrics. With the present child population in the United States of about 66,000,000, the ratio of specialists to children is not more than 1 to 84,000. The *active* practice of the average specialist for children (Board certified or not) furnishes medical care for approximately 1,000 children; such a case load affords him about 15 minutes for each visit with a patient—working at the pace of 60 hours a week. Thus to give every child in this country at the present time this sort of care would require 66,000 physicians designated as pediatric specialists. However attractive this might seem at first glance as offering opportunity in the specialty for new recruits, the most optimistic prophet would not argue that we will ever be able to provide every child with continuous care by a specialist in pediatrics.

It appears that a large proportion of children will continue to receive medical care from general practitioners and through public health facilities. By the very nature of things the pediatric specialist will have to offer a particular and exceptional type of care, and the members of the specialty will have to be content to exert an influence on others involved in child care through indirect channels. From the social point of view, sincere effort should be made to see that all children receive competent care. This means the pediatrician must share his knowledge and skills with others upon whom many children will have to depend.

Fortunately the vast increase anticipated in the child population will

be accompanied by greatly improved general health and a further lessening of serious illness. The improvement in general health will be a reflection of public health measures and not only the efforts of individual practitioners; the gross mortality in childhood in all countries has declined to the same extent with better socioeconomic conditions whether there existed a well developed specialty of pediatrics or not. The special care of children provided by pediatricians is a refinement that cannot be readily measured by gross mortality statistics—it represents concern for the individual among the masses.

The great majority of illness will be amenable to simple treatment. Therefore the special skills of a true specialist in child care should be directed at the smaller segment of the population for which they are actually needed, and no attempt should be made to bring every child under the supervision of a specialist. To do so would be to destroy the specialty as such, aside from creating an unsound economic setting for the pediatric practitioner and the patient.

Thus we return to the need for defining limits to specialty pediatric practice and for imposing increasingly exacting standards upon a limited number of practicing physicians who wish to be considered pediatric specialists. Steps must be taken to be certain a unique and significant service will be rendered. Only then can a proper value be placed on the pediatrician as a specialist and the public be expected to prefer his help where it is needed even though the cost is greater than ordinary care.

The alternative is to slowly drift into a more pedestrian form of pediatric practice which will earn correspondingly lessened respect and fail to attract men of exceptional ability. In spite of assertions to the contrary, there is no evidence that the present general family physician can give as good ordinary care to children as does the current group of pediatricians, but the future training of general practitioners can easily be improved so they could provide equally adequate ordinary care.

The present position of the pediatrician as a specialist is partly a historical accident—the natural outcome of the changing health scene—rather than the end-result of thoughtful adjustment to new demands. Pediatricians should now be willing to embark on a premeditated transfer of the bulk of ordinary care to better trained general practitioners and more adequate public health agencies, while assuming greater responsibility for improving the training of these groups. This is not to suggest a regression in health care for children by merely unloading ordinary care onto general practitioners no better qualified than those now generally available.

Whether by planning or by evolution, the present form of general practice of pediatrics will wither away and no longer be considered a

specialty if ordinary physical care garnished by superficial counselling is the main endeavor. It will simply be impossible to carry a large patient load and give genuine specialist care. Meanwhile the absorption of knowledge regarding children into the armamentarium of general practitioners, psychologists, social workers and public health agencies will enable them to become worthy rivals of the practicing pediatrician as he carries on his practice today. Sooner or later someone will set about evaluating the actual accomplishments of all groups claiming to be of service to children, and the pediatrician had better be engaged in the most sophisticated activities if he wishes to retain the rank of specialist. The kinds of skills embraced will tend to determine the nature of the persons each group will attract. And it is asserted again that love of children is not a skill or a quality upon which to build a specialty—those who dislike children form a more exclusive set!

The definition of the limits of specialty pediatric practice and the development of standards to be met by candidates are matters which logically should be looked after by the medical organizations concerned with the interests of pediatricians and the welfare of children. These functions must be carried out expeditiously as well as thoughtfully and with the needs of the children of tomorrow foremost in mind. The members of these organizations must be kept informed of the progress of deliberations on subjects so vital to them, and the opinions of the rank and file should be given due consideration. The leaders of such organizations are rightfully expected to lift our thoughts above immediate selfish interest and direct our attention to the needs of children in the future, and at the same time give legitimate attention to the economics of practice and the concept of the specialty held by the public and other branches of the medical profession. These are problems which require collective action—they cannot be solved by each individual for himself.

For the Educator

The elements of medical care of children that can be relegated to wholesale distribution by properly prepared general practitioners and suitable public health agencies should be identified by candid analysis. Then the nature of the training desirable for the general practitioner and the additional qualifications required to achieve specialist status will become clear. This means the educational programs would be devised to meet the needs of coming generations and not dictated by what seem to be unfilled demands of practitioners in the present. Otherwise we will be occupied with patchwork instead of substantial improvement.

The foremost obligation of the educator is to bear in mind that his primary function is to conduct an educational experience and secondarily to

provide a training program. An important distinction can be made between education and training. Education is the process of developing the use of the mind for sound and original thinking and objective evaluation of evidence. The function of training is to impart factual information which may serve as the raw material for thought or as a tool for practical use. Life in the schools is set aside for education; if it is not acquired there, it is not likely to be later. Training goes on throughout the educational process as an incidental activity in medical school and hospital residency and must never cease afterwards if the advances in knowledge are to be continuously absorbed. These processes may overlap, but awareness of their separate functions will do much to lessen confusion in selecting the arrangements made in the schools and in postgraduate programs to first educate and secondly train the various categories of persons intending to share in the medical care of children.

Ideally we may hope to give a basic education to all professional people but there is no justification for giving them all the same training. The group that is headed to dispense ordinary care has need of one sort of training—a certain body of knowledge—and the specialist or the investigator has different requirements. In other words, after a common basic educational experience they should receive further training according to their purposes. One postgraduate program cannot serve all groups equally well. At some point they must go their separate ways, and this must be before their formal training period is over and they have been launched into the practice of their professions.

To be more explicit: the undergraduate years in medical school are the formative period and the time to give priority to the educational process. What training the medical student receives in factual material on child care is of little consequence. In the early hospital training those heading for a general practice can be given the store of general knowledge suitable to ordinary child care. Those who choose to specialize in pediatrics should go on with residency training as long as necessary to master the finer ramifications of the subject and to fit them to cope with the rare and complex as well as the common and simple ailments. The pediatric educator should participate in the training of the many general practitioners who will be required to meet the needs of children for good ordinary medical care.

The number of residencies made available for specialist training in pediatrics should be sharply curtailed so that no more pediatricians are produced than can find places as genuine specialists. Otherwise the graduates of pediatric residencies will suffer the disillusionment of having to pursue their careers among a superior but frustrated group forced by their superabundance to do the work of general practitioners. The more intensive and prolonged training should be given only to that smaller

group who aspire to specialist qualifications. There must be a frank promise that pursuit of excellence will receive exceptional recognition—it simply takes more determination and ability to delve deeply into things.

To implement this proposal would require some daring moves by the leaders in pediatric education and a greater concern for the fate of those they train. Unless this is done the prospects for pediatrics as a specialty are not promising; only a few will have the courage and capacity to set themselves apart as specialists from a crowd that cannot claim distinguishing attributes for the services they render.

In reference to content, the specialist pediatrician should be chiefly oriented in physical illness, with the addition of that amount of knowledge of human behavior which will make him more effective as a physician. In general even the specialist pediatrician should not be equipped to be a profound counsellor in mental hygiene—aberrancies in this area will be left to some other professional group and the general mental health of the population will be assumed to be largely a social process beyond the reach of individual medical practitioners. If any medical group is to be prepared to serve as family counsellors, it had better be the general practitioners than specialists dealing with the young or the aged.

The academicians or chiefs of hospital services must not accumulate residents as cheap labor to carry on the service activities of pediatric departments or to act as technicians in research projects of the senior staff. This multiplication of jobs may be related to the increase in numbers of pediatricians beyond the call for specialists in child care. Better to use ordinary technicians for routine aspects of research work, more rotating general practitioner internes in the care of patients, and reserve a limited number of pediatric residencies for genuine specialty training. The residency program must be designed to cater to the training of the specialist and not insidiously conscript the resident in the service of the academic staff and the hospital services.

For Investigators

Preparation for a career in research in pediatrics presents no obscure difficulties. The investigator is trained by the basic scientists and he is entitled to concentrate on learning more and more about less and less. If the problem arises in childhood, the person who seeks its solution can consider himself engaged in pediatric research—and so will others look upon him. As long as there are unsolved problems presented by children, able men will be attracted to a career in pediatric investigation. What goes on in the laboratory is so far beyond the ken of the public that indulgence will always be granted the investigator to pursue his course with little public accountability. This is all as it should be for no one can predict the practical importance of a fact, no matter how remote its

relevancy to life's problems may seem. The worries of the investigator in pediatrics with respect to funds and fame are shared by all the medical scientists and will not be neglected. Besides, the competent investigator can be as gainfully employed in one field as another and the fate of pediatrics as a specialty need be of little concern to him.

The investigator may be housed in the academic pediatric department and be its proudest possession, but he is constantly threatened by the association with clinical medicine. To be sure, ideas spring from the clinical arena, but he must beware temptation to snatch a share of the naive admiration of students and patients; too much distraction can be the undoing of a sound investigator.

Pediatric investigators also need to set limits on their activities if they expect to retain their specialty status. Otherwise over a period of time the contributions from within the field of pediatrics will be characterized by superficiality and receive less serious respect from investigators in other branches of medical science. Some fear this has been happening of late and more time needs to be spent in the laboratory by those enlisted in pediatric investigation. The researcher cannot carry a considerable load of administration, teaching and patient care and be expected to do more than supervise mundane application of techniques developed by others; sophisticated fundamental research is a full-time job. These considerations apply equally well to scholarly effort in the behavioral sciences that is sure to be sponsored more in pediatric departments.

FROM THOUGHT TO ACTION

The spectre of the so-called practical man always hovers over the person struggling with broad concepts rather than specific details. These ghostly figures can be trusted to exploit what seems to fit their finite ends. We will founder if we depend on this sort of practicality. Nothing short of bold imagination can save us from premature decay. We must depart from the seemingly practical solutions of the moment and try to sense the grand outline of things to come. Only by this means can we prepare ourselves for the practical demands that we must face in the future. The influence of the philosophers of the past is with us still while their contemporaries among politicians and generals have had their day. The moral of history is that to make progress one should indulge in some thought before taking action, but to drift along in a dream world may bring stagnation.

The general considerations put forth can be translated into terms applicable to the future of pediatrics as a medical specialty:

1) Stake claims on only a manageable share of child care. Transfer ordinary medical care to better trained family doctors.

2) Base all claims on the future needs of children rather than the unfilled aspirations and personal characteristics of present-day pediatricians.

3) Take care to render a service that will be welcomed as unique and significant by coming generations.

4) Cling to the clear sanction given to physicians by medical licensure, and incorporate just so much of new approaches as will embellish traditional medical care and bring it into harmony with all other forces impinging on the child.

5) Preserve the prestige of the specialty by coupling excellence with exclusiveness. Count on this to attract an adequate supply of the most able candidates from the host of persons who love children.

6) Remember, the "whole child" is not the province of any one group but the object of interest for a diversity of disciplines. Furthermore, social forces can mould the individual as powerfully as any professional influences. Those who prefer to be chiefly counsellors will be free to find their place.

7) Consider the distinction between the essential educational process and the corollary training programs so as to expedite preparation of physicians for different careers in various aspects of child care.

8) Cultivate opportunities for basic research in academic departments and leave the investigator to wend his way unmolested.

9) Encourage leaders of medical organizations charged with the fate of pediatricians and dedicated to the welfare of children to accept the challenge to prepare for the future, high-mindedly and without delay.

10) The public must become aware of the assets of a genuine medical specialist in pediatrics; some suitable guidance may be necessary to modify their present expectations. Even the Gospel could not be spread without preachers.

For the future, one can envisage an improved class of family doctors and public health agencies providing ordinary health supervision and minor treatment to the great majority of children; a more highly trained, limited number of pediatric specialists giving consultation to family doctors in the care of major illnesses and disorders of development along with guidance in principles of health supervision; all of these receiving help from expert consulting specialists in the many subdivisions of pediatrics located in medical centers. Teaching and research in the development and disorders of children will be assigned to academic departments of pediatrics charged with preparing all sorts of personnel to meet the multitudinous needs of children.

Pediatrics has a rich heritage and an enviable content for a specialty. It must be passed on to future generations in a way the enormous potentialities can be realized. The most earnest planning will not succeed so well that we need fear too rigid a system of care for children in the future. Each individual will still be free to make his own kind of contribution.

Panel Discussion: What Is the New Pediatrics?*

WILLIAM S. ANDERSON, M.D.†
EDWARD DAVENS, M.D.‡
WILLIAM A. HOWARD, M.D.§
REGINALD S. LOURIE, M.D.‖
FREDERIC G. BURKE, M.D.¶
CHARLES D. MAY, M.D.**

Dr. Anderson:

During a recent visit to New York, I heard many interesting rumors from pediatric practitioners. One was that the departments of medicine of all the universities are quite eager to take the specialty of pediatrics back under their wing, especially since they think it should never have broken away. Another was that the general practitioner group is waiting like a vulture for pediatrics to die, so that it will take its share of the corpse. Finally I heard that some practicing pediatricians are seriously considering a new organization, a society for the preservation of general pediatric practice, outside the Academy of Pediatrics.

The feeling of one particular group was that the situation in effect today is not too far from what Dr. May has presented. After all, no physician in the general practice of pediatrics feels that he can cover the whole field; we are constantly calling on our confreres as consultants. I think most of us know our limitations. The need for a research group is certainly acknowledged, and no one disagrees that such persons should be relieved of administrative duties so that they can spend most of their time in research. However, the opinion was expressed also that those physicians in pure

* Presented as part of the Postgraduate Course in Pediatrics and Alumni Day at Children's Hospital, May 20, 1960.

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research benefit by contact with patients and should not entirely confine themselves to the laboratory.

Another point made during the same discussion is that there was a mistaken impression about the number of pediatricians who are completely disillusioned, dissatisfied, or unhappy with the multitudinous vicissitudes of practice. A great many pediatricians are very happy in what they do.

Personally, I feel that there is still a place for the part time teacher in pediatric training. I believe that every man, whether interested in either research or practice, has benefited from his knowledge of patient-parent relationships and those problems in the home, of which only the practicing pediatrician can be thoroughly aware.

Dr. Davens:

If I may dissent, I think Dr. May's approach, if taken to the extreme, might be somewhat on the regressive side. Recently the American Psyiatric Association met at Atlantic City. One of the primary themes of the whole meeting was how to get psychiatry back into medicine, how to set up more intimate relationships with the general practitioner, and how to heal the cleavage between mind and body which has existed so long in this country.

I constantly see community groups in action and see the splintering and fragmentation of skills that go into giving child care. I constantly feel that the "team" that is talked about—the large number of specialties and subspecialties giving a portion of this care—must somehow be coordinated. The approach of going back only to specialized physical aspects of medicine in childhood would remove from the present situation what I think should be a major purpose of the medical profession in adapting to the 1960 scene: to take leadership in acting as a captain of the team which together makes for better child health services. I would be unhappy from the point of view of someone interested in the broad field of maternal and child health if the pediatric branch of the medical profession should suddenly retreat and go back to a very much more specialized approach.

Let us look at the changes which pose the challenge to our adaptive ingenuity. The basic change, of course, is specialization with its increasing complexity and increasing cost of services, and the proliferation of all types of subspecialties. To adapt to that change makes a great deal of sense, because we are living in an organizational world, and the way to respond to this increased complexity of services is to have more organization. For example, a group of pediatricians working together could have a number of people from other specialties, such as psychologists, health educators, social workers, etc., working under their direction, and then be able to give a comprehensive type of care and still have time to go into

the really fine points of the clinical aspects of even the rare disease. It seems to me that the pediatrician, especially through the Academy of Pediatrics, has made a brilliant record of bringing leadership to the whole child health field and in setting standards of quality of care. It would be unfortunate in my view if anything is done to jeopardize this provision of responsible medical leadership for the health of the whole child.

Dr. Howard:

I would like to comment on the supposed dissatisfaction among pediatricians with their specialty. I was talking recently with a professor of pediatrics at one of our southern universities; he had taken the trouble to contact the graduates of the institution for the past 15 to 20 years. There were some 30 to 40 men in the practice of pediatrics, in various parts of the South as a rule. He found that almost to a man they were entirely happy in their specialty. This leads me to believe that when we talk to people individually, we do not get quite so much a story of dissatisfaction.

I would like to ask what place this so-called splintering of specialties within the field of pediatrics has in the pediatrician's life? I am speaking very personally, since I am an allergist as well as a pediatrician, and to me it has been a two-fold blessing. Yet, in a recent issue of the Pediatric Clinics of North America, Dr. Lewis Webb Hill speaks of the fact that there are now some 85 certified pediatric allergists; only about eight of those limit themselves to allergy. Where does the specialist in this field belong? How much should we center ourselves in our subspecialty, and how much in the comprehensive care represented by the general field of pediatrics? Allergists in general feel it is unwise to separate allergy from the medical treatment of the patient.

A final problem comes to mind. With the development of numerous health plans, many of which are already in existence, there seems to be every reason to believe that since the practice of medicine will not be limited to doctors, as such, in private practice, but will include groups of people banded together to do such a job, much of what the pediatrician does now will be lost to him. It will not take long for those administering insurance plans to discover very quickly that routine immunizations and office laboratory work can be done much more cheaply in bulk by technicians. On these things, at present, today's pediatrician depends for much of his livelihood.

Dr. Lourie:

In this thoughtful and often controversial treatise, Dr. May is pointing to the very sensitive parts of the whole pattern of pediatric training. For one, I am glad that he opened up the subject of the selection of the people

who should be specializing in medical work with children. I was delighted to hear him call attention to poor bases for making such a choice of a life's work. It is because of a poor basis for selection of trainees that we see many of the defections from, and dissatisfaction with, the field. As we have had a chance to observe trainees, fortunately we have found relatively few young men in the field of pediatrics merely because their object in life is to tell mothers what to do, but there are some of those with us. We find others who are in the field because they are uncomfortable with adults, a very poor basis for selecting this field as a life's work. From Dr. May's presentation we have an indication that we need to do a great deal more thinking about how we pick the people who will be pediatricians and particularly we must take their motivation into account.

Dr. May raises the question as to what is the place of the behavioral sciences in pediatrics. Many of us have been through the phases in which there was a struggle to get them included. I would feel that perhaps Dr. May has indicated that the pendulum is swinging back. Many of us would be distressed if this were to be true. I have had the feeling, as I have worked in the pediatric setting, that maybe the eventual place of child psychiatry would be in pediatrics. The child psychiatrists themselves have felt strongly enough that the field of pediatrics is so close to their work that a pediatrician sits with the new accrediting Board of Child Psychiatry. I believe that a swing away from this trend would be a step backward.

A former Wall lecturer, Dr. Julius Richmond, stated that one of the paradoxes in pediatrics has been that it has had to turn to the behavioral disciplines for the information and the body of thinking on which it bases much of its practice. For example, it has had to call on the child development workers, the psychologist and the psychiatrist—the people of the behavioral sciences in general. We are now seeing a trend for pediatricians themselves to investigate these fields where they fit into the pediatric scene, and they are making fundamental contributions. It becomes increasingly clear that we cannot disregard the constitution as we are trying to assess behavior. Who has greater access to the intricacies of what goes into making the variations in the constitution than the pediatrician? It is from the field of pediatrics that we are beginning to find the directions in which we can deal with most important aspects of behavior: look at the findings on the inborn errors of metabolism, the problems of genetic differences, and chromosomal variations in various kinds of disorders in constitutional makeup which underlie behavioral problems.

Why should only physical growth and development be the concern of the pediatrician? In fact can we really separate physical and mental development? It is very true that there are degrees of intricacy of psychopathology which need to be turned over to people who are working specifi-

cally with such problems, but it has been estimated that 80 per cent of problems which children present in their formative stages are superficial and are certainly within the province of the pediatrician. I would hope very much that he would not abdicate his place in dealing with them.

I want to thank Dr. May for his challenging look at the future of pediatrics. It is very necessary for us to be stimulated in this way into thinking and rethinking through our directions if we are to meet the challenges and responsibilities of our field.

Dr. Burke:

An important feature suggested by Dr. May concerns the necessity for the re-evaluation by physicians in pediatric practice of their own motives in relation to their profession. I am certain that most physicians select medicine as a profession with some sense of dedication to be in a position to help his fellow man. This dedication is an aspect of pediatric practice that should not be underestimated. In the pursuit of personal excellence, it should always be remembered that there is no mutual antagonism in wedding this satisfaction with sick children's needs.

The continuing development of high standards of pediatric care in this country in the past has been basically motivated by the response of intelligent physicians to these very needs of sick children. It is certainly true that the definition of these needs has shifted from time to time. At the turn of the century, an appalling death rate, associated with diarrheal disease, rickets, celiac disease, infectious diseases, and lack of understanding of what constitutes good health, led to a concerted barrage of research activities which have led, in turn, to a reduction in infant and child mortality and the production of one of the highest standards of care given to children of any country.

Between 1910 and 1920, the sad condition of premature infants as a group came under fire; the development of more precise physiologic knowledge and development of mechanical devices plus a constant restressing of established nursing principles has resulted in a remarkable decrease in mortality and a reduction in the importance of this as a pediatric problem. More recently, the development of the antibiotic and chemotherapeutic agents has resulted in the far superior control of bacterial infections which is commonplace today.

Currently, the need for the comprehension and application of good principles of preventive medicine has been largely met. Pediatricians are now accepting the responsibility of such major problems as congenital malformations and mental retardation. The future of pediatrics requires a sorting out and further definition of the everchanging disease scenario as it affects normal growth and development. Pediatricians have no worry

about invading other disciplines, if necessary, to find the answer to these future problems, whether they lie in the area of emotional disorders of childhood, in the management of juvenile delinquency and other problems of adolescence, or in teratological research as would be involved in the field of congenital malformations. The changing nature of the challenges in pediatrics is in itself a keen stimulant to further pediatric research interest at the practicing level.

I am in some disagreement with Dr. May's approach to the solution of the problem of being all things to all men in pediatric practice. While it is true that all areas of the broad field of pediatrics will seldom be comprehended by any single individual, the dedication of two years of training to a subspecialty area within the pediatric field would occur to me as a practical answer to combining the satisfactions of caring for the needs of children in the private practice of pediatrics with the need of the physician himself to acquire an intellectual and academic excellence in a particular area. At Georgetown we have attempted to encourage three basic years in training in clinical pediatrics, with one or two further years of training in cardiology, allergy, renal physiology, etc. It is also possible that those who are overwhelmed with the excellent salesmanship effect of preventive pediatric practice might gain considerable satisfaction from developing an interest in a particular field such as mental retardation, or possibly interesting themselves in juvenile delinquency as it exists in their community; those interested in a particular clinical entity might so train themselves in postgraduate courses as to assume a fair competency in such a subspecialty.

I do not believe there is as great a general dissatisfaction in pediatric practice as has been intimated. Future educational programs for pediatric trainees, however, should have in mind the advisability of developing pediatric subspecialty training programs. These will develop pediatricians who are not only concerned with the needs of children but who have, in addition, the self-satisfaction of the pursuit of their own standards of excellence.

Dr. May:

I am not here to propose any particular plan. What I am asking is that we attempt to give such orderly thought to the subject as to be able to crystallize some of the issues and bring them into consideration simultaneously. I think one observes in letters to the editor and in private discussions that it is quite easy to get off on one aspect or another of the issue with intense feeling, without necessarily relating it to the whole. We should endeavor to identify as many of the elements as we can from these discussions and put them together in such a way as to think about them in a comprehensive manner

I really cannot see why there should be any intense feeling in the matter. Some people have thought it quite unwise that any such discussion as this should take place, saying that it plays upon existing anxieties, and we are apt thereby to discourage people unnecessarily. But an unexpressed concern or one that is not dealt with is, in the long run, more threatening than one which has been brought out in the open and worked out to a satisfactory and constructive conclusion. I also hope that almost anyone would appreciate that all of us believe intensely in the validity of our specialty. Our concern really is why it is that people have raised some of the questions or misgivings that they have. If we are interested in attracting able men to enjoy the experience we have had, then we must realize that it is important to be concerned about the general feeling, whether or not it is expressed. Thus, along with our analysis of the problem, there needs to be a constant re-expression of our confidence in our abilities and in the significance of our activities. One has no difficulty in presenting eloquent portrayals of the more moving aspects of pediatrics which could appeal to anyone with sensitivity and with ideals.

In any single exposition on this subject one is not able to exhaust all aspects of it. If I have not today, for example, painted the glories alone, it is not that I am not perfectly capable of doing so, and actually would enjoy doing so to a greater degree. I am not, however, a partner to the idea that everything that goes on around us must be "positive." There is a place for higher criticism and an analysis of where we stand; we should be able to do so without becoming defensive when someone raises the possibilities of improvement.

The question may well be raised as to what portion of general medical care should be given by one group rather than another. One school of thought is that the internist and the pediatrician should become partners in dividing the family between them as a form of general practice. As the number of internists increases and our numbers increase, we find ourselves meeting in the middle; ultimately we may fuse into one and once again have, by evolution, a more competent generalist. Some medical schools are actually embarking upon a predetermined effort to create persons who really are better internists and better pediatricians than past generations of general practitioners have been. I refer to Stanford University, where the term generalist is being used a great deal, as it has been in a recent Surgeon General's report. One can imagine all sorts of ways this matter could evolve, or of setting about to plan its course.

In the office, and in the day's practice, there is the matter of both hours and economics to face, as well as the matter of personal satisfaction or dissatisfaction. It is surely necessary to make choices as to how much time will be spent at one thing or another. This is the question which faces us: namely, is there a part of child care which can best be given by the kind

of person who is trained to be especially competent in a true specialty of pediatrics, and are there other parts of care which can be disseminated by the health agencies which are being conducted by Dr. Davens and others? I think one either conducts himself in a haphazard way and perhaps allows control of the situation to elude his grasp, or he thinks about it a little more coherently and sets about in a more determined way to fill his proper role. For it certainly makes a great deal of difference if we are going to produce more of Dr. Davens' type of pediatrician working in the community and put such young men through the now traditional form of pediatric residency training and leave them wondering whether or not they should be experts in metabolic disease when they get out, or whether we separate persons aiming toward care of children in a more general sense from those who are going to go to that degree of specialization manifested by some of the experts in the academic realm. There can be an effort at least to define the need and arrange the training and the opportunities accordingly. What I believe desirable for those organizations charged with the welfare of practitioners of pediatrics would be to undertake that degree of systematic analysis of the problem which would define needs and define corresponding requirements in training and education, rather than depend too much on an individual and trial and error basis for solutions.

The problems which face pediatrics are part of the problems which face medicine as a whole. There is a falling-off of applicants in medical schools which has been quite conclusively demonstrated for several successive years. If we are going to have physicians to serve the people, we must continue to attract sufficient numbers of capable people. This means that we must impress them with the fact that they will have a rewarding career, in the sense of its being a significant one in fulfilling some unique need.

What I am asking is whether pediatric practice shall progress along the line of becoming a general practice among the young, or whether it shall endeavor to maintain itself as a specialty. It is certainly equally inviting either way as far as I am concerned, but it is a question that we should consider. For example, take the field of infant feeding; one must ask whether or not it is a sufficiently challenging sophisticated endeavor to advise the mother how to feed an infant to attract adequate numbers of people in the pursuit of this career, or whether this is a body of knowledge which has been brought to such a state that it can be transferred to other persons who enjoy this kind of activity.

As I have pointed out, I am proposing what many will consider an unrealistic suggestion: the re-creation of a truly competent general physician whose career is made attractive by restoring to him some of the general care which he might enjoy as his unique contribution, while others proceed to enjoy their particular specialized contribution.

I think I could say to our future pediatricians that they need have no

misgivings whatsoever about the appeal of pediatrics as a career. I can think of no better opportunity to expand oneself to the fullest, to use every facet of one's intellect, personality and character, each and every hour of the day. If anything is discouraging to us, it is that the challenge is so enormous; we are constantly possessed with the feeling of almost suffocating humility. This is, however, a field which is full of enormous appeal, and it will not disappoint any person, even though he may grumble in some superficial fashion about his working conditions from time to time. But one should gain from this discussion, if he is on the threshold of considering pediatrics as a career or has just embarked on this career, that what he is witnessing is only a legitimate concern that the future which unfolds before him will be as rich as the period we have enjoyed.

Waiting Room Observation in Pediatric Practice

EMMA M. LAYMAN, Ph.D.*

The purpose of this paper is to describe a technique devised in a psychiatric setting which is applicable in the pediatrician's office as an aid in providing him with information useful in dealing with emotional problems.

It is a well publicized fact that about 50 per cent of the patients of general practitioners suffer from some form of emotional disturbance.[1] No comparable figures are available for pediatric practice, but any physician working with children will agree that much of his time is spent in counseling with parents about problems that are at least partly psychogenic in nature or are unrelated to organic functioning. It is the pediatrician to whom the parents turn with questions and concerns about the child who is unusually fearful, has temper tantrums, is not accepted by other children, cannot learn to read, will not tell the truth, sucks his thumb, or watches television instead of doing his homework. It is the pediatrician who is consulted about the child who is enuretic, who cannot sleep, or who has physical complaints that cannot be entirely explained on a somatogenic basis. The pediatrician is expected to supply answers to the parents' questions concerning what they should do to help the child.

Recognizing that counseling in the area of the prevention and handling of emotional disturbances is an important function of the pediatrician.

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medical schools are tending to include "pediatric psychiatry" in the offerings of the department of pediatrics, and medical students are having clinical experiences in this area as a part of their pediatric training. There is a growing trend also to include experiences in a psychiatric service as a part of the training of the pediatric resident. Recognizing the importance of acquiring useful information about practical means of dealing with personality problems, physicians are relying less on "rules of thumb" in giving advice to parents than was true even a few years ago. However, the pediatrician with training in dealing with emotional and behavior problems is still faced with the problem of how he can take the time to make psychiatric studies without neglecting other aspects of his practice. There is a continued need for tools and techniques for obtaining essential information quickly and easily.

In the "team" setting of the multidisciplinary child guidance clinic, the diagnostic work-up ordinarily requires at least five to seven hours of scheduled time, exclusive of time spent in the diagnostic staff conference. For the child psychiatrist in private practice, a minimum of four to six hours ordinarily would be required. This would be the equivalent of a good many office visits for the pediatrician or family doctor. The physician working with children, of course, gets to know a great deal about his patients and their parents as he sees them during repeated visits to his office and in his visits to the hospital, so that over a period of time he has opportunities to make observations which are perhaps much more extensive than those it is possible to make in the average psychiatric study. However, many of these observations are not recorded and much is overlooked when the child is being seen for a problem that is not a psychiatric one.

Waiting Room Observation as a Diagnostic Technique

It has been said that "science begins with the observation of selected parts of nature."[2] Like scientific method in general, the clinical method is based on observation. All diagnostic procedures utilize observations, whether these involve taking a temperature or sphygmomanometer reading, making a note of dilated pupils, listening for rales, or observing a facial tic. In the psychiatric clinic for children the observation consists principally of the "noting of behavior as it occurs."[3] The psychiatric social worker records the observations of parents, teachers, and others who have had contacts with the patient. The psychiatrist observes the patient's reactions to certain situations in a playroom setting. The clinical psychologist observes the patient's responses during psychological testing. In addition to making these observations, all members of the clinic team observe and to some degree interpret the spontaneous behavior of the child and his parents while in the clinic.

Traditionally, in the psychiatric clinic observations are made principally in the offices of the psychiatrist, psychologist, and social worker, and in the playroom. In recent years, however, increasing use has been made of observations of parent and child which have taken place in the clinic waiting room where both the patient and his parents are less aware of being observed than when in an office or playroom. Similar waiting room observations lend themselves to use in the anteroom of the pediatrician's office, serving as a time saver for acquiring information about children with personality problems.

Construction and Use of Waiting Room Observation Form

In a preliminary study conducted by the Department of Psychiatry of Children's Hospital, an attempt was made to identify and define the behavior patterns which might be conveniently observed in the waiting room of a psychiatric clinic for children, and to construct a guiding outline indicating specific behavioral incidents to be observed and recorded. This was accomplished in four steps, as follows: a) A collection was made of incidental waiting room observations reported by members of the professional staff of the Department of Psychiatry and recorded in the clinic charts of 100 children. To this collection was added the observations made by secretaries for 10 cases seen in the Department of Psychiatry and observations on 15 children and their mothers made by nursery school teachers in the waiting room of the hospital Well Baby Clinic. b) The observations were broken down into specific behavioral items, and these were classified in terms of general areas of behavior or development. c) The lists of areas and items were presented to the members of the staff of the Department of Psychiatry for discussion; this resulted in the deletion or addition of some items and reclassification of others. d) An observation outline based on the staff discussion was prepared. The outline served as the basis for a form to be used in recording observations.

The form consists of three parts. Part I is used for recording the circumstances under which the observations were made. Part II is an observation check-list on which the observer checks items descriptive of the characteristics or behavior patterns which he observes and writes in explanatory phrases as needed. Part III is a blank space on which the observer writes a narrative, chronological summary of his observations. Inasmuch as most observers will take abbreviated notes, and since many observations are in the periphery of consciousness at the time they are made, the use of the check-list serves to remind the observer of items which he might forget to include in his narrative summary, and the narrative report is a supplement to the check-list. However, either Part II or Part III may be used independently.

The 269 descriptive and behavioral items included in Part II of the observation form are classified under the following headings:*

I. Entering clinic
   A. General observations of parent-child relationship
   B. Behavior of child
   C. Behavior of parent
II. Child's characteristics and activities
   A. General appearance and behavior
   B. Speech
   C. Facial expression and posture
   D. Motility and coordination
   E. Tics and habits
   F. Requests made of adults
   G. Activities engaged in
III. Parent's characteristics and activities
   A. General appearance and behavior
   B. Speech
   C. Facial expression and posture
   D. Motility and use of waiting room space
   E. Tics and habits
   F. Activities
IV. Child-parent relationships
   A. Closeness, contact, and communication between parent and child in waiting room
   B. Parent's behavior toward child
   C. Child's behavior toward parent
V. Child's relationship with sibling, if sibling present
IV. Child's relationships with other children (not siblings)
VII. Child's and parent's reactions to children and other adults in the waiting room
   A. Child
   B. Parent
VIII. Separation patterns—reactions to examiner's approach or parent's leaving
   A. Child
   B. Parent
IX. Reactions to reunion after separation
   A. Child
   B. Parent
X. Leaving clinic
   A. General behavior
   B. Reactions to leaving clinic

Used in the psychiatric clinic, the Waiting Room Observation Form was found valuable as an aid in analyzing disturbances in communication behavior in children and their parents,[4] with observations being made principally by clinic secretaries. More recently the form has been used by the Children's Hospital Nursing Education Staff for the training of student nurses in observational techniques. In this connection the students have

* Copies of the complete observation form, with manual, may be obtained from the Department of Psychiatry, Children's Hospital, Washington, D. C.

made observations in various clinic settings at Children's Hospital—in the Medical Clinic, Orthopedic Clinic, Cardiac Clinic, Eye Clinic, Neurology Clinic, Lead Poisoning Clinic, Well Baby Clinic, and others. An analysis of the material obtained in these observations and comparisons of this material with information on some of the patients known to the Department of Psychiatry indicates that these observations, made in nonpsychiatric settings, may have much to contribute to the understanding of a child's emotional problems. This can best be illustrated by pertinent case material.

CASE REPORTS

Case 1

A. H. is a 4 year old white boy in whom a diagnosis of cerebral palsy, athetoid type, was made at the age of 10 months. He has had frequent colds all his life and had convulsions from the time he was 4 hours old until 8 months of age. Since the age of 8 months the convulsions have occurred not oftener than once in two months and have usually followed temper tantrums. The seizures have been tonic-clonic in nature, are accompanied by unconsciousness, have lasted three to five minutes, and have been controlled with phenobarbital. Development has been very slow. The child did not walk until 3 years of age, still walks very poorly, and does not talk. An electroencephalogram was performed at 30 months and reported as normal.

A. H. is an adopted child who has lived with his adoptive parents since soon after birth. He has a 2 year old brother who is the natural child of the adoptive parents and who apparently is developing normally.

This patient was observed by a student nurse in Neurology Clinic during his third visit to the clinic. Observations were made in the waiting room and in the examination room.

Summary of Observations

A. H. is a boy of about average size who was brought to the clinic by his mother. Both mother and child were neatly and appropriately dressed. Mother and child arrived together, hand in hand. When greeted by the clinic nurse the mother responded in a friendly manner. She removed both her coat and the child's, and sat down calmly to wait for the doctor. While waiting she talked quietly with other parents and seemed quite relaxed. She did not appear embarrassed about the child's condition, talked about him easily, and answered questions asked by the nurse. She described A. H. as a "happy, affectionate" child, and said that he had a good appetite but was difficult to feed at times. She said that at one time she had almost "given-up"—when he was nearly 3 years old and still was unable to walk. She said also that he was loved by her other child and that the two played together well.

A. H. is a boy who was observed to have very poor motor coordination. He walked on a broad base, with a somewhat staggering gait and poor balance. In handling things around the clinic he was awkward in the use

of his hands. He was quite hyperactive—running around the clinic, going after objects on the desks, and generally getting into things. During the waiting period, although he moved around, from time to time he returned to his mother. He would hit her leg, hug her, hold out his hand to be kissed, or ask her to do something for him (such as button his sweater). The child has no speech, and "asks" by using gestures and squealing. The mother did not seem irritated, but responded to A. H. by holding him, kissing him, giving him an affectionate pat, smiling at him fondly, or helping him.

On entering the examination room A. H. walked up to one nurse and pulled her hand. He then ran around the clinic, apparently showing no fear of the 10 or 12 nurses present. He approached the observer, extending his hand, and the mother explained this meant that he wanted his hand to be kissed. He then continued to dart about the clinic. When in danger of hurting himself or getting into something which he shouldn't handle, the mother sometimes warned him to "be careful" or to "leave that alone," and he usually reacted positively to her correction. When he fell down, the mother was comforting and reassuring and the child did not cry.

At the end of the session mother and child left the clinic together, hand in hand. Neither appeared upset nor in any special hurry to leave.

Interpretation of Observations

The observations made by the nurse concerning this boy's gait, stance, general coordination, vocalizations, and hyperactivity, together with the mother's statements to her about the developmental history, fit in with the physician's diagnostic impression of mental retardation resulting from brain damage. The child's behavior in relation to his mother and to the nurses suggests that this is a child who trusts people and is confident that his need for affection will be met. The mother's behavior, too, indicates that she understands and accepts this child and is adequately meeting his needs for dependency and love. To some extent, she helps him in control of impulses, but is not entirely consistent in this. Although, because of the motor and speech handicaps, it is difficult to predict what his intellectual potentiality may be, it would appear that the mother-child relationship is such as to make it seem likely that the child will develop without gross personality distortions. The one area in which the mother seems to need assistance is in seeing the importance of setting limits and doing a more consistent job of helping the child with problems of self-control.

In this case, although there was a referral to the psychologist for psychometric tests, the information provided in the observational report of the nurse was sufficient to serve as a basis for counseling with the mother concerning the child's emotional needs.

Case 2

C. M. is a 10½ year old Negro boy who has diabetes and a history of convulsions. He has a mildly abnormal electroencephalogram, with right frontotemporal focus. He has been treated in Diabetic Clinic and Neurology clinic, and has been studied diagnostically in the Psychiatric clinic. Referral to Psychiatry was made on the basis of the aunt's complaint that he is hard to control. He fights with other children and steals food when attempts are made to keep him on a diet. The patient has spent most of his life with various relatives in North Carolina. Three years ago his parents disappeared, and two years ago he was taken by a maternal aunt and uncle to live with them in Washington because of a lack of medical facilities in the North Carolina community where he had lived. The move took place immediately after the diagnosis of diabetes mellitus was made. The aunt reports a marked personality change in the boy during the past two years.

The patient was observed by student nurses in the Neurology Clinic and the Medical Clinic.

Observations

1. *Neurology Clinic.* C. M. was noted to be a neatly dressed 10 year old boy of about average size, who was observed with his aunt during their second visit to Neurology Clinic. The child appeared unhappy and depressed, while the aunt impressed the observer as one who felt that a great burden had been placed on her.

C. M. followed his aunt to the clinic. He turned away in silence when greeted by the nurse, and the aunt gave a monosyllabic response. They sat together while waiting to be seen, but the patient did not speak to his aunt, and she ignored him except to speak angrily and tell him to hurry when he left to go to the toilet. (This happened twice during a 30 minute interval.) He read a comic book while waiting, and did not communicate with any of the other patients.

In the examination room, the patient sat in a small chair and most of the time appeared not to be attending to what was being said by the doctor and his aunt, although occasionally he would watch them briefly and seem to be listening. He sat slumped over, played with his fingers, and sucked his thumb. The aunt would tell him to take his thumb from his mouth, but he would soon be sucking on it again. From time to time he would close his eyes and rock back and forth. When questioned by the doctor he would smile inappropriately, would wait several seconds before replying, and then would respond in a whisper. While C. M. was in the clinic the doctor drew pictures on the board to explain diabetes. The patient smiled at the pictures but looked upset when the word "diabetes" was mentioned.

Like the child, the aunt appeared unhappy and sat slumped over, but talked in a loud voice. When reporting on the child's inability to hold his urine she did so with an air of resentment. She asked the doctor about how to use a new insulin syringe that she had, and when she showed the proce-

dure she had been using, it was apparent that she had been giving too much insulin. When this was pointed out to her she became quite agitated and confused, denied that she had given too much, and said she had been putting it on the right mark. (Public Health nurses reported that she had, in fact, been using the syringe incorrectly and had given too much insulin.)

In C. M.'s presence the aunt stated that he had been quite a bother to her and she had planned to send him back to North Carolina because her doctor had advised her to send him back because of her own health. However, the night before he was to leave he had a convulsion which lasted for 45 minutes, and this frightened her so that she changed her mind about sending him away.

As C. M. and his aunt left the clinic the aunt lingered to speak to the nurse and the boy walked out alone, still looking depressed.

2. *Medical Clinic.* C. M. was seen in Medical Clinic the day after the examination in Neurology Clinic. The student nurse made some of the same observations as had been made the day before, noting the lack of closeness between aunt and child and the fact that the aunt complained extensively to the nurse about the child's behavior. However, on this occasion both aunt and patient seemed stiff and tense. C. M.'s behavior in some respects was different from that noted in Neurology Clinic, but in other respects was the same, as indicated by the following report:

Although C. M. had been to this clinic before, he seemed apprehensive and bashful. He talked only when asked questions by the doctor, and replied briefly. When called to the examining room he stood outside the door after his aunt had entered, and it was necessary for the nurse to go after him. He was reluctant to remove his clothing, so was undressed by the nurse and doctor. He was wearing two pairs of underpants, and the aunt scolded him about this. After he had dressed and the doctor left for a few minutes, C. M. grabbed his aunt's scarf, put it over his head, and dashed into the waiting room. The aunt called out to him to stop because he might get hurt or might hurt someone, but he ignored her and continued running around the waiting room until stopped by the nurse. Except for this incident, the aunt acted as if C. M. were not there during the entire time that they were in the clinic.

Interpretation of Observations

On the basis of the information given in the medical chart and that supplied by student nurses making observations, it is apparent that C. M. is quite a disturbed child, with problems that stem from a combination of organic and psychogenic factors.

As far as personality is concerned, C. M. is an unhappy, depressed, withdrawn child who feels that nobody loves him and has to comfort him-

self by recourse to infantile patterns of thumb-sucking and rocking. He does not know how to relate to others except on the basis of aggressive behavior, which forces others to react to him. He has difficulty with various aspects of control, particularly in controlling his urination and controlling his aggressive impulses. The wearing of extra underclothing suggests that he is embarrassed and distressed about his enuresis. This, plus his reluctance to be examined, suggests also the possibility of a fear of bodily hurt. Denial of his illness is suggested by his stealing of food.

On the basis of the history of this child and observations of the child and aunt, it would seem that C. M. has become a child who alternates between withdrawn and aggressive behavior partly because he has never been really wanted by anyone. The persistence of infantile patterns suggests that he never has had his most basic dependency needs met. To him, people are to be withdrawn from because they have nothing to offer or are to be struck out against because they are rejecting. With the physical findings added to the picture it could be postulated that the patient's depression, reflecting a feeling of worthlessness, is due to the combined effects of an awareness of physical inferiority and an awareness that others have little use for him. The apparent impulsiveness could be partly on the basis of a mild organic brain damage, and partly on the basis of annoying others sufficiently to force them to attend to him. There is the additional possibility that the impulsive outbursts are C. M.'s way of saying that he cannot control himself, and so must have someone else control him. It is quite evident that the aunt with whom he is living is not adequate to the task, and that she cannot be relied on to administer the insulin in appropriate doses.

Psychiatric Study

The psychiatric study of C. M. included three interviews with the aunt, a play interview with the child, and a psychological examination of the child. In the summary of the study, the child was described as depressed and withdrawn, having problems with impulse control, being concerned about separation from his relatives in North Carolina, fearing bodily hurt, and feeling helpless. It was noted that he tends to deny that he has diabetes and also that the long comas he has had, combined with extreme malnutrition, may have resulted in some brain damage. The psychiatrist concluded, "We would think of this child as one who is certainly being immobilized by the physical and emotional problems which are preoccupying him at this time and would think of his need for short term therapy."

Comparing the picture obtained from the psychiatric study with that obtained from observing the child and aunt in the medical and neurology clinics, we find that they are almost identical.

DISCUSSION

The cases presented, and others of a similar nature, indicate that nurses can make observations in waiting rooms, offices, and clinics which may provide very useful information about a child and his parents. When evaluated and interpreted by the physician, such observations are helpful from the standpoint of contributing to an understanding of emotional problems and pointing to areas in which the parents need guidance. Particularly when the physician must direct his attention to procedures of physical examination and treatment, the nurse may observe behavior and characteristics of the parent-child relationship which escape the doctor's notice. Also, many parents let down their guard and perform differently in the waiting room with the nurse or receptionist than when they feel that they are being judged by the doctor.

It would seem that systematic and careful observations made by the nurse or receptionist in the pediatrician's office could be just as valuable as those made in a clinic. The usefulness of these could be increased if the waiting room were equipped with a toy corner or play area, so that the observations would include information concerning the child's reactions to different toys and descriptions of the nature of his play.

Those uninitiated in the use of waiting room observations have raised questions concerning the amount of training needed in order to make adequate observations and the difficulty of recording observations when the observer does not know shorthand. Experience with secretary-observers and student nurse-observers indicate that people can be good observers without having a great deal of training, especially if observation is made their job. Also, the use of check-lists, supplemented by brief notes, has made it unnecessary to use observers who are shorthand experts.

SUMMARY

1. The pediatrician devotes much of his time to counseling with parents and dealing with emotional problems, but usually does not have the time to take detailed psychiatric histories or to make extensive behavioral observations of the child.

2. Waiting room observations and observations in the examining room have been found to provide valuable material which may be used as an aid in understanding children and parents with emotional problems, whether the observations are made in a psychiatric clinic or in some other type of medical clinic.

3. The pediatrician with a receptionist or office nurse might well benefit from the use of similar time-saving techniques in the setting of the office from which he conducts his private pediatric practice.

4. The setting up of a toy corner in the waiting room of the pediatrician's

office provides an opportunity to make particularly valuable observations of the child as he expresses himself through his play.

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Editorial

WHAT IS THE FUTURE OF PEDIATRICS?: A CREDO

In the past few years certain self-appointed sages in scattered ivory towers have continued to predict, with increasing frequency, the end of the specialty of pediatrics as now constituted. The great majority of these predictions come from physicians who have never been in active pediatric practice, but have always been in research and full time hospital and teaching activities. These ominous forebodings are most discouraging to the younger practitioner in pediatrics and to the members of the house staffs in pediatric training centers. Recently they are beginning to influence medical students in consideration of pediatrics as a specialty. It is gratifying, however, to see in the various pediatric journals the expressions of a contrary opinion by leading proponents of pediatric practice from all parts of the country.

Pediatric practice today varies with the locale and size of the area concerned. In small towns and rural areas, the pediatrician acts as a consultant to the internist and the general practitioner. In cities, however, the pediatrician is in active competition with the general practitioner and the internist, and all too frequently the school health programs. Pediatricians, of necessity, have to do a thorough general practice within the age group. In recent years pediatrics has finally included the adolescent group, a long neglected progressive move. It is admitted that more than 50 per cent of all children are cared for by general practitioners, but the more than 7000 pediatricians form a progressive group, mostly within the Academy of Pediatrics, to work toward such goals as better child care, better Public Health practices, and improved preventive medicine.

Many pediatricians today cultivate a subspecialty and this should be encouraged, but every pediatrician must continue as a family counsellor. With limited psychiatric facilities and an increasing case load, we must continue to handle minor behavior and emotional problems. Dr. Lourie's training program here at Children's Hospital is geared to this concept. Dr. Layman's excellent suggestions concerning "Waiting Room Observation in Pediatric Practice" can be incorporated in all our offices. It took years to adopt the approach to the care of the "whole child". Dr. Adolph Meyer termed it psychobiology; it later became known as a psychosomatic attitude. It would be a backward step to divide the patient again. Pediatricians realize their limitations along this line, and consultation is requested when necessary.

In the "New Pediatrics", it has been suggested that physicians in research be separated from clinical contacts in order to allow more time in the laboratories. Dr. Edwards Park and Dr. Grover Powers insisted that all research pediatricians continue to make rounds on the clinical wards, as well as do daily teaching in the outpatient departments. This is being done in most pediatric clinics today, and is an integral part of the over-all program of our own Children's Hospital.

The financial straits of most hospitals and medical schools is an ever increasing problem. Building funds are more readily available than sustaining funds. If the future care of all children in the home and office is to be entirely in the hands of the general practitioner, all hospital care, teaching and research will be in the hands of highly trained staffs of pediatric specialists. These physicians will, of necessity, be full time and salaried. This will be an expensive program which will be an impossible financial burden for most hospitals. Further governmental subsidies could lead into socialized medicine similar to that in England today.

What is the future of pediatrics? After 25 years of practice with a university affiliation for part time teaching on the wards and in the outpatient department, I have some dedicated beliefs:

I believe in the future of the specialty of pediatrics as now constituted.

I believe in the future of children's hospitals.

I believe in the concept that better patient care, both private and indigent, is given in a children's hospital with both a research and a teaching program.

I believe that the best pediatric training program exists in hospitals where the pediatrician in active practice is utilized in teaching to balance the science of pediatric training with the art of pediatric practice, particularly for those members of the resident staff who plan to go into practice.

I believe that the increasing shift in patient load from inpatient to outpatient care will be met by new diagnostic facilities which will utilize the talents of the pediatric practitioner to an even greater degree.

I believe, finally, that the continued progress of pediatrics will evolve through joint efforts of the American Academy of Pediatrics together with the American Pediatric Society and the Society for Pediatric Research—leading the way toward our common goal.

WILLIAM S. ANDERSON, M.D.

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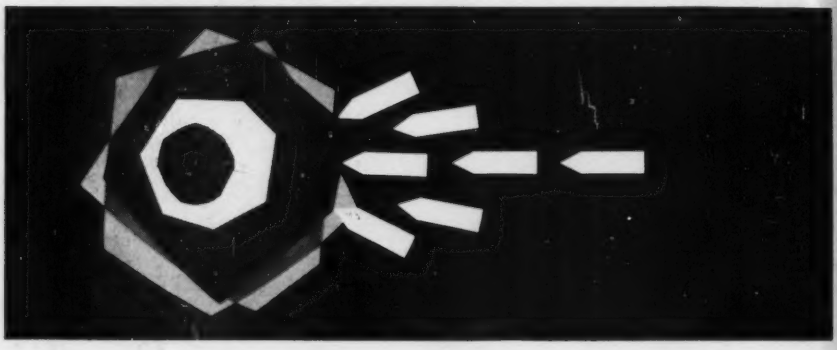

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